ON THE MANIFESTATION OF NEGATIVE POLITENESS IN DOCTOR-PATIENT INTERACTION

Miroslav Černý

Abstract

There is a general agreement that research into doctor-patient interaction is a much-needed discipline. Both linguists and medical specialists have provided deep and long-term analyses of medical consultations. However, several aspects of medical interviewing, for example the manifestation of politeness, have so far received little attention. The present contribution attempts to investigate linguistic devices that are characteristic of negatively polite behaviour. It also presents a comparative analysis of doctor-patient interviews in different medical environments.

1 Introduction

The purpose of the article is three-fold. First of all, I attempt to analyze some means of manifesting politeness in doctor-patient interaction in order to either confirm or contradict the findings of previous research. Second, my aim is to compare the productivity of negatively polite linguistic strategies that occur in institutional settings with those that are characteristic of authentic communication in non-institutional settings. Third, the present paper offers a "communicative comparison", in other words, a comparative analysis of doctor-patient interviews in different branches of medicine.

In this article I have drawn upon the following sources: (1) The theories of politeness as advocated by Brown and Levinson (1987), Fraser (1990), Lakoff (1973), and Leech (1983) represent my main sources of information about negative politeness strategies. (2) My interpretation of politeness devices that occur during doctor-patient interaction draws, for instance, on Fisher (1983), Gwyn (2002), Henzl (1989), Mishler (1984), Paget (1983), Shuy (1983), and Todd (1983). (3) The material on the basis of which I carry out the comparison of the institutional and non-institutional discourse is taken from Wilamová (2005). As she argues, her conclusions, though valid only for fictional dialogue, could also be relevant for authentic communication.

The language material for the present inquiry is taken from a corpus of conversational texts recorded in consulting rooms throughout Great Britain and the United States during the 1990s, available in the book *English for Doctors* edited by Györffy in 2001 (see References). For the purposes of the analysis I have investigated doctor-patient interviews from five specialist branches of

medicine: Internal Medicine, Gynaecology, Paediatrics, Oto-rhino-laryngology, and Orthopaedics. The total extent of the material under scrutiny is 725 turns, and the total word stock amounts to 12,000 items.

2 Methods of Analysis

According to Paget (1983), "… politeness forms are frequently deleted from [medical] discourse. They are almost entirely absent from the speaking practices of the physician in these encounters" (ibid.: 59). As she maintains, a typical example of this impoliteness is the doctor's failure to answer questions posed by the patient. Paget also criticizes doctors for not acknowledging the responses of the patient and for the insufficient clarification of their inquiries.

The results of my investigation (see Černý 2007) differ considerably. Most patient-initiated questions are answered by doctors, and doctors usually spend a huge amount of time clarifying and interpreting their diagnoses and the subsequent treatment. Moreover, doctor-initiated medical terminology, understood by some researchers (e.g. Shuy 1983) as an instance of impoliteness, is usually provided with a polite explanation so that there is no misapprehension on the part of the patient.

Without any shade of doubt, it is obvious that Paget's opinion (1983) – that politeness forms are almost entirely absent from doctors' contributions to the encounters – cannot be taken for granted. In what follows, I bring quantitative and qualitative evidence that politeness devices occur quite frequently in doctor-patient communication, both on the part of the doctor and the patient, within all the medical branches under scrutiny, and during all the parts of the medical interview.

Since the quantitative analysis presupposes a limited number of strategies to be investigated, I have decided to research only those linguistic devices that are characteristic of negative politeness. The reason for my decision is that negative-politeness behaviour, in my opinion, is more likely to take part in institutional settings, of which doctor-patient communication is a representative example, than strategies typical of positive politeness. Moreover, such a choice allows me to compare my findings with those investigated by Wilamová (2005).

As the analysis of her data has shown, "there are four basic linguistic strategies that occur in negatively polite discourse, namely (1) *'I'/'You'* avoidance (Avoid); (2) distancing strategy (Dist); (3) modal verb choice strategy (Modal); and (4) stylistic choice" (Wilamová 2005: 40). To satisfy the needs of the comparison, I have included, in accordance with her research, only the first three strategies to my quantitative analysis. Stylistic choice has not been mapped because it would be quite difficult to organize its quantification. More importantly, the comparison of branches of medicine is also drawn based upon a qualitative interpretation.

3 Findings

The procedure described in the preceding paragraphs yielded the following results: from 725 turns I managed to excerpt 177 negatively polite devices. One hundred and fifty one (85%) are initiated by doctors and 26 (15%) are initiated by patients. A closer examination of Tables 1 and 2 reveals that 99 (56%) devices belong to the category of *'I'/'You'* avoidance strategy, one (1%) to the distancing strategy, and 77 (43%) to the modal verb choice strategy. Forty one (23%) politeness devices originate during the history-taking phase, 71 (40%) during the phase of examination, and 65 (37%) during the phase of treatment.

Abs.	**Particip**		**Phase**			**Strategy**			**Total**
	D	*P*	*Hist*	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	26	11	11	26	0	27	1	9	**37**
Gynaec.	34	4	2	22	14	16	0	22	**38**
Paed.	30	5	15	5	15	10	0	25	**35**
ORL	38	2	5	9	26	31	0	9	**40**
Orthop.	23	4	8	9	10	15	0	12	**27**
Total	**151**	**26**	**41**	**71**	**65**	**99**	**1**	**77**	**177**

Table 1: Absolute frequency of politeness strategies in D-P interviews

%	**Particip**		**Phase**			**Strategy**			**Total**
	D	*P*	*Hist*	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	70	30	30	70	0	73	3	24	**21**
Gynaec.	89	11	5	58	37	42	0	58	**21**
Paed.	86	14	43	14	43	29	0	71	**20**
ORL	95	5	12	23	65	77	0	23	**23**
Orthop.	85	15	30	33	37	56	0	44	**15**
Total	**85**	**15**	**23**	**40**	**37**	**56**	**1**	**43**	**100**

Table 2: Relative frequency of politeness strategies in D-P interviews

Shuy (1983) advocates that doctor-patient communication is in many aspects similar to everyday conversation; it is structured and organized. At the same time, he stresses the fact that medical encounters differ from everyday conversations; especially as regards balanced participation in the interaction. Correspondingly, having compared my findings based on the analysis of medical interviews with the results of the research based on the analysis of normal conversation, both

similarities and differences can be found. First of all, let me examine the points of similarity; the points of divergence will be analyzed later.

The frequency of occurrence of structural lexico-grammatical devices presented by Wilamová (2005: 79) is as follows: The total number of negatively polite devices in her corpus is 86, of which 31 (36.0%) politeness devices belong to *'I'/'You'* avoidance strategy, 17 (19.8%) of them to the strategy of distancing, and 38 (44.2%) to the modal verb choice strategy, which is the most numerous category.

In addition, Wilamová also distinguishes sets of subcategories for particular linguistic strategies. These are the process of nominalization (Example 1), using *'IT'* as a subject (Example 2), *'THERE+TO BE'* construction (Example 3), *'WE'* as a personal pronoun strategy (Example 4), and using impersonal or indefinite subjects/objects (Example 5) for *'I'/'You'* avoidance strategy. Examples of these subcategories excerpted from the material that has been researched in the present article are supplemented below.

(1) D: *Is this **your first pregnancy**?*
(i.e. Are you pregnant for the first time?)
(2) D: *And the delivery itself; **was it** Caesarean, a forceps or **was it** normal?*
(i.e. Did you have Caesarean or did you have a normal delivery?)
(3) D: *Yes, that's right, although if **there are** any abnormalities on any of the smear…*
(i.e. although if you have any abnormalities …)
(4) D: *OK. That's good. **We** just need to do a little internal examination now.*
(i.e. I just need to examine you.)
(5) D: *Do any **problems** run in the family?*
(i.e. Do you have any problems …)

The distancing strategy is divided into two substrategies, namely the distancing verb and the distancing demonstrative. As for the modal verb choice strategy, it is subdivided into modals expressing obligation or prohibition (Example 6), modals asking for permission (Example 7), modals expressing volition (Example 8), ability (Example 9), tentative possibility (Example 10), and hypothetical usage (Example 11). As Wilamová (2005) points out, "the classification here draws on Leech's (1975) functional typology of modal verbs, which provided the theoretical background for a further study of modal verbs in negatively polite discourse" (Wilamová (2005: 56). Examples of these subcategories selected from my corpus are again offered below.

(6) D: *I **would advice you** not to take any alcohol.* (i.e. I want you not to take ...)
(7) P: ***Could I ask you**, Doctor?*

(8) D: *Hello, Mrs Smith.* ***Would*** *you like to undress James?*
(9) D: *I* ***can't*** *give you any guarantee that they will not return.*
(10) P: *I'm afraid I* ***might*** *have asthma.*
(11) P: *I feel tightness in my chest, so I thought it* ***would*** *be wise to come in and see you.*

Notably, in both samples, the most frequent negatively polite strategies are *'I'/'You'* avoidance (56%, 36%) and the modal verb choice strategy (43%, 44%). Furthermore, as can be seen from my examples, all subcategories of particular strategies are represented in the samples under discussion. It should also be pointed out that these linguistic strategies perform similar functions within the discourse. As regards modals, "they enable the speaker to go on record, but with redress, which is achieved with minimum linguistic effort" (Wilamová 2005: 77). As for *'I'/'You'* avoidance, its function is to evade direct reference both to the speaker and the hearer, thus contributing to a higher degree of negative politeness.

Proceeding now to the points of divergence, it is worth mentioning that there is only one linguistic device from the distancing strategy in my sample (Example 12). By contrast, there are seventeen devices in the sample presented by Wilamová (2005). In my opinion, a possible explanation for this divergence could be sought in the way in which the distancing strategy functions. As Wilamová maintains, "this device allows the speaker to distance himself in time (i.e. distancing from 'now') and hence distancing from an FTA" (ibid.: 54). However, as regards medical interviews, this function has no beneficial effect on the process of doctor-patient communication.

Intuitively, both the doctor and the patient tend to avoid the use of distancing devices, because it could clash with the main purpose of medical interviews, that being responsible diagnosis and treatment. It is crucially important for the doctor to know when exactly his patient's health problems started and for how long they have lasted. As a result, they carefully observe the most suitable use of tenses (Example 13), and for being polite they prefer other devices, for instance the above mentioned *'I'/'You'* avoidance strategy. Maybe that is the reason why this strategy is more frequent in my material I have consulted than in the material used for comparison.

(12) P: *I* ***thought*** *it would be wise to come in and see you.*
(13) D: *What* ***seems*** *to be the problem* ***at the moment****?*
P: *Well,* ***I've been feeling*** *so poorly* ***recently****.*
D: *I see. Feeling poorly. What* ***do you mean*** *by that?*
P: ***I've been getting*** *very short of breath.*

The last examples reveal that negative politeness devices are used very frequently in institutional settings – particularly in the surgeries of doctors – even more frequently than in non-institutional conversation. By contrast, in terms of the number of particular types of linguistic strategies, non-institutional talk is more diverse, and takes advantage of all of the structural lexico-grammatical devices under scrutiny. Generally speaking, these results support the idea that the institutional talk is more structured, predictable, and organized around a limited number of topics that must be pursued (cf. Fisher 1983: 141). In everyday conversation, on the other hand, speakers are allowed to be more spontaneous, unpredictable and creative, yet polite.

4 Doctor-initiated politeness strategies

As has been proven in the research carried out by other linguists (e.g. Shuy 1976), the amount and distribution of speech during doctor-patient communication is rather asymmetrical. According to Byrne and Long (1976), on average a medical interview lasts eight minutes. Most of the time is exploited by doctors for the purpose of information-gathering, examination, and treatment. Patients are usually more passive and the period of time they spend talking is, compared to the doctor's talk time, very short. Consequently, it is the doctor whose initiation of politeness strategies is more frequent.

Out of the total number of negatively polite devices excerpted from the corpus (177), 151 (85%) are doctor-initiated. Eighty four (56%) politeness devices belong to the category of *'I'/'You'* avoidance strategy, 0 (0%) belong to the category of distancing strategy, and 67 (44%) may be included to the category of modal verb choice strategy. Thirty six (24%) negatively polite devices take place during the history-taking phase, 55 (36%) during the phase of examination, and 60 (40%) during the treatment section (see Tables 3 and 4).

Abs.	**Phase**			**Strategy**			**Total**
	Hist	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	9	17	0	18	0	8	**26**
Gynaec.	1	19	14	14	0	20	**34**
Paed.	15	3	12	9	0	21	**30**
ORL	4	8	26	31	0	7	**38**
Orthop.	7	8	8	12	0	11	**23**
Total	**36**	**55**	**60**	**84**	**0**	**67**	**151**

Table 3: Absolute frequency of doctor-initiated politeness strategies

%	Phase			Strategy			Total
	Hist	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	35	65	0	69	0	31	**17**
Gynaec.	3	56	41	41	0	59	**23**
Paed.	50	10	40	30	0	70	**20**
ORL	11	21	68	82	0	18	**25**
Orthop.	30	35	35	52	0	48	**15**
Total	24	**36**	**40**	**56**	**0**	**44**	**100**

Table 4: Relative frequency of doctor-initiated politeness strategies

A more detailed examination of Tables 3 and 4 reveals several interesting points. As can be seen, the largest number of politeness devices occur during the treatment section, and involve both the category of *'I'/'You'* avoidance strategy and the modal verb choice strategy. As has been shown in the previous research (e.g. Humphreys 2002), the treatment phase is in many aspects specific; the examination of the patient is over, and the doctor already knows the diagnosis. Now the doctor's task is to inform the patient about his/her health problems and future treatment. In many cases, especially when a surgical intervention is required, a more polite way of informing the patient suits the situation (Example 14).

(14) D: *You've got a deviated nasal septum. This part of your nose is cartilage, and instead of being straight it's twisted and the twist is blocking you on the left side. I'm pleased to say we can fix it for you. We can put it right with an operation to straighten up your nose, as there are no medicines or tablets really that will help.*
P: *Is it a big operation?*
D: *No, not too big. It's quite common. If you agree, we'll bring you into hospital the day before the operation. You can usually go home the day after your operation, or possibly the second day after that. We do it under a general anaesthetic. It's done through your nostrils, there's no cuts on you face.*
P: *No black eyes?*
D: *Not for this operation. When you wake up from anaesthetic, you'll probably have a bandage up both nostrils overnight so, you see, you'll have to breathe through your mouth that night. Would you like the operation?*

As regards the choice of modal verb, it is not difficult to explain why this category of negatively polite strategies is so numerous: "English modals represent extremely flexible devices which not only have a grammatical function (i.e. as helping words), but which also carry a 'semantic' meaning that 'colours' the propositional content of the message" (Wilamová 2005: 77). In this respect, modal

verbs function as very important negatively polite devices in both institutional (e.g. medical consultation) and non-institutional environments.

Of greater interest is the function of *'I'/'You'* avoidance strategy and its subcategories. The use of the inclusive *'we'* in doctor-patient communication is particularly worthy of discussion. Doctors, unlike patients, often substitute the address pronoun *you* by the first person plural pronoun *we* (Example 15). According to Henzl (1989): "The preference of *we* in addressing patients is common across the whole medical profession, and shifts in pronominal use mark the speech of medical personnel of all levels and specializations" (ibid.: 88). The results of the quantitative analysis calculated for the five medical branches under discussion give this opinion statistical support.

(15) D: *Keep breathing through your mouth, just let the water run out of your nose. Well done, it's coming back clear now. We can stop.* (i.e. You can stop)

The qualitative interpretation of the function of the inclusive *'we'* reveals that doctors tend to employ this device because "it avoids explicit reference to either the speaker himself or to the addressee" (Wilamová 2005: 47). Nevertheless, it also reflects asymmetry in the social status of the interlocutors. It is the doctor who exercises the power by making decisions for the patient (Henzl 1989). By contrast, the use of the inclusive *'we'* initiated by the patient would be considered rather impolite.

Besides the inclusive *'we'*, doctors also make use of the so called exclusive *'we'* (Example 16) or its pronominal modification *'us'* (Example 17). In this case, however, the pronoun *we* performs a different function. It fulfils the need for self-protection and self-defence. Although it is not likely that patients would carry out face-threatening acts, doctors still tend to protect themselves by withdrawing from the responsibility for potentially unsuccessful outcomes of their treatment.

(16) D: *Well, the wax looks quite soft, so* ***we'll*** *syringe it.* (i.e. I will syringe it.)
(17) D: *This wax is too hard for* ***us*** *to get out now.* (i.e. This wax is too hard for me.)

As regards the manifestation of doctor-initiated politeness, there are two further discourse strategies worth considering, namely the 'presentational' and 'persuasional strategies'. Both strategies are described as 'negotiating mechanisms' that provide information, and suggest or specify how the information should be understood (Fisher 1983). The presentational strategies are described as 'soft sells'. To clarify their function, Fisher mentions the following: "For example, a practitioner would say, 'We usually treat this by freezing.' This presentation

provides the patient with information about treatment option while suggesting that it is the usual or normal way to treat her condition" (ibid.: 143).

The persuasional strategies, on the other hand, are labelled as 'harder sells'. Fisher offers the following example to explain their use: "For example, a practitioner might say, 'What you should do if you don't want any more children is have a hysterectomy. No more uterus, no more cancer, no more babies, no more birth control, and no more periods.' This presentation provides the patient with information about what treatment she should have while specifying why she should have it" (ibid.: 143).

In terms of negative politeness, it seems to me that the presentational strategy is less imposing, and hence more polite than the persuasional strategy. In terms of asymmetry, the 'soft sell', unlike the 'harder sell', "places the patient in a position where they could, if they wished, question not only the treatment, but the thinking behind it. Therefore, this strategy is significant in balancing the asymmetry between doctors and patients" (Humphreys 2002: 34). In connection with my corpus, the presentational strategy is the more frequent. Moreover, it is embedded in all the medical disciplines under consideration (see Examples 18, 19, 20).

(18) D: *I can feel a little lump underneath my fingers and what that indicates to me is that he's got some overgrowth of the muscles at the exit of the stomach, and that it is blocking the material like his milk draining from his stomach so I think that it's likely that what we need to do is a small operation to cut through the muscle and relax it.* (Paediatrics)

(19) D: *We have got the results of your biopsy, and I'm afraid we will need to give you more treatment for your voice.* (Ear-nose-throat)

(20) D: *Warts can be treated by freezing them with liquid nitrogen but I think the best way to treat your warts would be to put some podophyllum paint on them.* (Obstetrics and Gynaecology)

5 Patient-initiated politeness strategies

As mentioned above, patients infrequently carry out potentially face-threatening acts. According to Fisher (1983), they "rarely say aloud that they do not trust their medical practitioners or that they suspect them of trying to manipulate the situation" (ibid.: 137). Correspondingly, "Ainsworth-Vaughn presents only two examples from her data, one in which a woman covertly questions her physicians competence, the other in which a male patient makes blatant sexual references to both his (female) physician and (off screen, as it were) to female nursing stuff" (Gwyn 2002: 78).

Accordingly, we may characterize the patient's behaviour as very polite. It is influenced, of course, by the social role he/she plays in doctor-patient interaction. Unlike the doctor, who is supposed to provide a health service, the patient is the one who waits, suffers, and is treated (Gwyn 2002). It is no surprise that his/her relationship with the doctor is very polite – or to be more accurate, negatively polite.

Although the space/time for the employment of patient-initiated politeness strategies is limited, I have managed to excerpt 26 negatively polite devices in the corpus under investigation. Fifteen (58%) negatively polite devices belong to the *'I'/'You'* avoidance strategy, one (4%) to the distancing strategy, and ten (38%) to the modal verb choice strategy. Five (19%) of them occur during the history-taking phase, 16 (62%) occur during the examination phase, and five (19%) during the treatment section. For details on particular medical disciplines see Tables 5 and 6.

Abs.	**Phase**			**Strategy**			**Total**
	Hist	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	2	9	0	9	1	1	**11**
Gynaec.	1	3	0	2	0	2	**4**
Paed.	0	2	3	1	0	4	**5**
ORL	1	1	0	0	0	2	**2**
Orthop.	1	1	2	3	0	1	**4**
Total	**5**	**16**	**5**	**15**	**1**	**10**	**26**

Table 5: Absolute frequency of patient-initiated politeness strategies

%	**Phase**			**Strategy**			**Total**
	Hist	*Exam*	*Treat*	*Avoid*	*Dist*	*Modal*	
Internal	18	82	0	82	9	9	**43**
Gynaec.	25	75	0	50	0	50	**15**
Paed.	0	40	60	20	0	80	**19**
ORL	50	50	0	0	0	100	**8**
Orthop.	25	25	50	75	0	25	**15**
Total	**19**	**62**	**19**	**58**	**4**	**38**	**100**

Table 6: Relative frequency of patient-initiated politeness strategies

In accordance with the basic division of the medical interview into three phases (history-taking, examination, treatment) and in accordance with the main functions of these phases, the largest number of politeness devices are initiated by patients during the phase of examination (Example 21). This part of the medical encounter is the longest, and it is not reserved merely for answering doctor-initiated questions (like the information-gathering part, i.e. history-taking), or for doctors' explanation and clarification of therapeutic procedures (as is the case with the phase of treatment).

(21) P: *What would you advise, Doctor, about dressing him at night time for sleep, because I've heard different views on this.*

Since the function of negatively polite strategies has already been considered, let me complete this section by mentioning one more interesting point. As is shown by Tables 5 and 6, most patient-initiated politeness devices occur in the surgery of a doctor specializing in internal medicine (11; 43%). Although the number of negatively polite devices initiated by patients is quite low, we may speculate that the explanation is to be sought mainly in the fact that doctors of this specialization are not visited too often; certainly less than, for instance, paediatricians (in the case of children) or gynaecologists (in the case of women). As a result, patients are not so familiar with this branch of medicine, and manifest more respect and polite behaviour towards internists (Example 22).

(22) P: *I feel tightness in my chest, so I thought it would be wise to come in and see you.*

6 Concluding remarks

I hope to have demonstrated that politeness forms play a very important role in doctor-patient interaction. Considering the manifestation of negative politeness in the surgeries of various medical specialists, we have seen that the largest number of negatively polite devices employed by doctors occur during the treatment section, and involve the categories of the *'I'/'You'* avoidance strategy and the modal verb choice strategy. Unlike patients, doctors often substitute the address pronoun *'you'* by the first person plural pronoun *'we'*, especially the inclusive *'we'*. Doctors also make use of the exclusive *'we'* or its pronominal modification *'us'*, and prefer so called presentational strategies to persuasional ones. By contrast, patients never initiate the use of the inclusive *'we'*. It is also worth noting that they very rarely carry out face-threatening acts.

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